Express Pharmacy Services

(Mail-Order form for Eckerd Health Services)

Mail Service Prescription Enrollment Order Form

This form is to be used by participants enrolled in the Triple Option and Two Option Medical Plan to obtain a maintenance prescription through the Mail-Order Program. The mail-order facility, Express Pharmacy Services (EPS), is owned and operated by Eckerd Health Services.

If you have never used the Mail-Order Program before with Express Pharmacy Services, you must complete all sections of this form (including the confidential patient profile), and sign and date the form. If you have used Express Pharmacy Services in the past, you can either use this form to order more prescriptions, or use the order form you received with your prescription order from EPS. You need to sign and date the form. If you have completed a Mail Service Prescription Enrollment Order form previously, you only need to complete the confidential patient profile section if any of the information has changed.

The copayments for up to a 90-day supply through the mail are $12 for a generic prescription, $28 for a brand name preferred prescription, and $40 for a brand name nonformulary prescription. If you have a question about what is on the formulary, call Eckerd Health Services at 1-888-249-5041.

Please mail the form, copayment, and the original prescription(s) to:

Express Pharmacy Services
P.O. Box 419096
Kansas City, MO 64179-0844

You can expect delivery of your order within 14 calendar days from the date you mailed it.

(Press tab to start filling in form.)

SF 4400-EPS # (2-2000) Supersedes (1-99) issue

Member Name _____ **Sandia National Laboratories**

Address _____
Street City State Zip

Daytime Phone ( ) _____ Home Phone ( ) _____

Member Number/Social Security Number _____

CONFIDENTIAL PATIENT PROFILE

Member _____ Date of Birth _____ Sex ☐M ☐F
Last Name First MI

Allergies (check boxes) ☐None ☐Penicillin ☐2 Chocolate ☐3 Sulfa ☐4 Aspirin
HEALTH CONDITIONS ☐5 Thyroid ☐6 Diabetes* ☐7 Glaucoma ☐8 Heart Condition ☐9 High Blood Pressure
Other health conditions/allergies _____
*Indicate the type of supplies being used - _____
Monitor Lancets Test Strips

Spouse _____ Date of Birth _____ Sex ☐M ☐F
Last Name First MI

Allergies (check boxes) ☐None ☐Penicillin ☐2 Chocolate ☐3 Sulfa ☐4 Aspirin
HEALTH CONDITIONS ☐5 Thyroid ☐6 Diabetes* ☐7 Glaucoma ☐8 Heart Condition ☐9 High Blood Pressure
Other health conditions/allergies _____
*Indicate the type of supplies being used - _____
Monitor Lancets Test Strips

Dependent _____ Date of Birth _____ Sex ☐M ☐F
Last Name First MI

Allergies (check boxes) ☐None ☐Penicillin ☐2 Chocolate ☐3 Sulfa ☐4 Aspirin
HEALTH CONDITIONS ☐5 Thyroid ☐6 Diabetes* ☐7 Glaucoma ☐8 Heart Condition ☐9 High Blood Pressure
Other health conditions/allergies _____
*Indicate the type of supplies being used - _____
Monitor Lancets Test Strips

Dependent _____ Date of Birth _____ Sex ☐M ☐F
Last Name First MI

Allergies (check boxes) ☐None ☐Penicillin ☐2 Chocolate ☐3 Sulfa ☐4 Aspirin
HEALTH CONDITIONS ☐5 Thyroid ☐6 Diabetes* ☐7 Glaucoma ☐8 Heart Condition ☐9 High Blood Pressure
Other health conditions/allergies _____
*Indicate the type of supplies being used - _____
Monitor Lancets Test Strips

PLEASE READ AND SIGN: I certify that the information provided on this form is correct and that the prescriptions enclosed are for use by eligible participants. I certify that I or my dependents for whom prescriptions are enclosed do not have primary prescription drug coverage under any other group medical plan. I also certify that the enclosed prescriptions are not eligible for reimbursement under a Worker's Compensation Program. I authorize the release of all information to the Plan sponsor, administrator or underwriter.

Member Signature _____ Date _____

PRESCRIPTION ORDER FORM FOR NEW PARTICIPANTS

Prescriptions are for: ☐Member ☐Spouse ☐Dependent

Childproof caps are used for safety in shipping. ☐**Check here if you want non-childproof caps with this order.**

Please write the member number on the back of each prescription.

Brand-Name Prescriptions
Quantity: _____
Copay: $ _____
Total: $ _____

Generic Prescriptions
Quantity: _____
Copay: $ _____
Total: $ _____

Payment is being made by: ☐Check ☐Money Order ☐Credit Card
Please make check or money order payable to:
Express Pharmacy Services.
Do not send cash.

If paying by credit card, indicate the credit card you wish to use and provide the account number and the expiration date:

☐JCPenney ☐Novus/Discover ☐Master Card ☐VISA ☐American Express

Credit Card Account Number: _____ Expiration Date: _____

Signature: _____ Date Signed: _____